Paying for Value: Higher Quality, Lower Costs

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Paying for quality

- Pay for performance (quality) has been accepted
- Measures of quality have been developed by many sources
- **Value = quality/cost**

Value Based Purchasing (VBP)

- Center for Medicare Services (CMS) has had VBP program where **hospitals** are paid for reporting 32 quality measures
- CMS also has paid for voluntary **physician** quality reporting initiative (PQRI)
- Neither reward is based on actual performance, only **reporting** (so far)

Paying for quality by insurers

- **Wellmark** has program called Collaboration on Quality which pays for improved care (processes and results)
- This program has been successful, not only in promoting better processes and better **outcomes** for patients (e.g. diabetes, hypertension) -- it has **reduced costs** for patients in the program

Why we need to pay for value

- **Unsustainable increases in healthcare costs**
- **Our current payment system rewards the most expensive care,** not the most **effective care**
- Our current system rewards **volume**, not **value**
- If we want better quality (better outcomes) and more efficient care we should reward **value**

Quality measurement

- Over 500 various measures of quality, some are **process** (e.g. giving antibiotics), some are **outcome** (e.g. lipid levels, mortality)
- **Iowa Healthcare Collaborative** reports numerous hospital measures
- www.Hospitalcompare.gov website also compares hospital quality measures
- Some quality measures are better than others
- Quality measurement continues to evolve

How does Iowa compare in quality?

- CMS hospital measures (Jencks): **6th**
- AHRQ (Agency for Healthcare Research and Quality) hospital, ambulatory, nursing home and home health measures: 4th
- Commonwealth Fund: **second** in overall system function (access, prevention and treatment, costs, equity, and healthy lives)
- So if quality and efficiency are both measured (**value**) Iowa is second!

Why we need to pay for value

1) We can't afford to keep paying for volume, the cost increases are unsustainable

2) Dartmouth research has shown higher quality and efficiency are related

3) If we want better results at lower cost, we should reward value

4) This is the most effective way to reduce healthcare costs—don't pay for **unnecessary** or **ineffective care**

How do we know there is unnecessary or ineffective care?

- Dartmouth research on geographic variation- "Over 30% of health care costs are wasted"
- Miami $16,300 vs. Iowa at $6,200-$6,800 per patient/year Medicare expenditures
- We could save over 30% if all regions practiced like Midwest
- There are opportunities to improve, even in Iowa

Healthcare reform

- PPACA (the new law) has a number of initiatives and innovation to pay for value
- House version: **Institute Of Medicine** (IOM) to develop pay for value incentives
- Senate version: CMS to develop a **Value Index** (pay for value geographically)

When/how will Pay for Value begin?

- If IOM and CMS differ, which prevails?
- Geographic Pay for Value (Value Index) has huge resistance from populated states (CA, NY, MA, TX)
- IOM is likely to bring better results and will likely use accountable care organizations (ACOs) as the entity to reward Pay for Value

Pay for value issues

- Measurement is still evolving
- Which measures, or group of measures?
- Easier to measure large entities, regions
- Resistance for individual physician practices because of small numbers, variability of patients ("my patients are sicker")
- Don't penalize "good docs" in regions
- Complexity of reporting (need EMR)

Which entities to measure/reward: Region, hospital, individuals?

- **Geographic** adjustment, reporting are already being done (Iowa comes out ahead)
- **Hospital** measures reflect physicians on staff (Dartmouth recommends this level)
- Reporting burden is done now by hospitals- but do they report accurately?
- **Individual** physician measures are currently not accurate

Individual physician measures

- Though measures of individual physicians might be possible, patients vary (& studies show measurement accuracy is poor)
- I don't believe **individual** physician quality or cost measures will ever be **accurate** enough to use (attribution, small numbers, etc.)
- But many multi-specialty groups want to be accountable for quality and cost (ACOs)

My prediction: Accountable Care Organizations ACOs

- Even independent practice physicians can join IPAs and cooperate with 1) EMR and 2) measures of quality and cost (be accountable)
- Physicians who don't want to use an EMR and be accountable for meaningfully using the EMR to help them with decision support and coordination of care will be left with shrinking fee-for-service (volume-based) pay

Pay for Value: Payment reform

- With ACOs, care can focus on keeping patients healthy and out of the hospital
- Patient-centered **medical home**, and **medical neighborhood** are the foundation for an **ACO**

- **The difference between an HMO and ACO is that the ACO is accountable for quality/cost, not just cost**

What is the future for Pay for Value?

- "**Meaningful use" of EMR** will have embedded quality measures and reporting + decision support (to make the right choice)

- I hope **perfect** will not be the **enemy** of the **good** (we have good measures now so let's not wait forever)

Geographic equity: Accurate cost measurement

- CMS currently uses inaccurate measures of physician practice expenses (GPCIs). Medicare **geographic payment inequity** may be perpetuated unless accurate practice cost measures are used by CMS.
- Reforming the payment system to Pay for Value needs both **accurate measures** for quality and cost